WESTERN CARDIOTHORACIC SURGEONS

Darryl Stein, MD  Fadi Khoury, MD  Daniel Eads, MD
1830 S. Alma School Rd, Suite 108, Mesa, AZ 85210
Phone: (480) 248-3000  Fax: (480) 248-3050

# Patient Registration Form

## Patient Demographics

Name (Last, First Middle) _____

DOB _____ Social Security # _____ Driver's License # _____ State of Issue _____

Street Address _____

City _____ State _____ Zip _____

Secondary Address _____

City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____

(Work) _____ Please Check Preferred Phone? Home ____ Cell ____ Work ____

Email _____

Sex: Male Female Gender _____ Dominant Hand? Right Left

Preferred Language _____ Race _____ Ethnicity _____

Marital Status? Single Married Widow Divorced Sig Other Spouse/Sig Other Name: _____

Employed? Full-time Part-time Retired Student? Full-time Part-time

Primary Care Physician _____ PCP Phone _____

Address _____

City _____ State _____ Zip _____

Referring Physician _____ Phone _____

Address _____

City _____ State _____ Zip _____

Emergency Contact _____

Emergency Phone Number _____ Relation to Patient _____

## Insurance Information (Please completely fill out insurance information)

Primary Insurance Company _____ Phone _____

Insurance Address _____

City _____ State _____ Zip _____

Policy Holder Name _____ DOB _____

Employer _____ Relation to Patient _____

Policy ID Number _____ Group Number _____

Secondary Insurance Company _____ Phone _____

Insurance Address _____

City _____ State _____ Zip _____

Policy Holder Name _____ DOB _____

Employer _____ Relation to Patient _____

Policy ID Number _____ Group Number _____

I hereby authorize Western Cardiothoracic Surgeons, to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to physicians ALL payments for medical services rendered for myself or my dependents. I understand that I am responsible for ANY amount NOT covered by my insurance company. I am responsible for any unpaid amount and agree to pay court costs, including any attorney fees which are incurred in the collection process.

I release that payment under the medical insurance program be made to Western Cardiothoracic Surgeons on any bills for services furnished to me by Western Cardiothoracic Surgeons. I authorize Western Cardiothoracic Surgeons to release to the Social Security Administration, or its intermediaries, or carriers any information needed for this claim or related medical claims. I further permit copy of this authorization to be used in place of the original. This authorization is further to apply to all private insurance claims for my illness.

The patient or patient representative, recognizing the need for care, consents to all or any services as ordered by the physician, including lab procedures, medical treatment, minor or emergency surgical treatment, exam, or other services rendered under the specific instruction of the physician.

Signature: _____ Date: _____

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Patient Name _____ DOB _____

## Medications, Allergies, & Pharmacy

**Medications:**

| | | |
|---|---|---|
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |
| Name _____ | Dose_____ | Frequency _____ |

**Allergies:**

☐ No Known Drug Allergies

| | | |
|---|---|---|
| Drug _____ | Reaction _____ | Severity _____ |
| Drug _____ | Reaction _____ | Severity _____ |
| Drug _____ | Reaction _____ | Severity _____ |
| Drug _____ | Reaction _____ | Severity _____ |
| Drug _____ | Reaction _____ | Severity _____ |
| Drug _____ | Reaction _____ | Severity _____ |
| Drug _____ | Reaction _____ | Severity _____ |
| Drug _____ | Reaction _____ | Severity _____ |

Have you ever received the Annual Flu Vaccine? Yes No If yes, approximate date of last dose? _____
Have you ever received the Pneumonia Vaccine? Yes No If yes, approximate date of last dose? _____

Pharmacy _____ Phone _____
Pharmacy Address _____
City _____ State _____ Zip _____

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Patient Name _____ DOB _____

## Historical Information

Please explain why you are being seen in our office today?

_____

_____

Do you drink alcohol? Yes No If yes, how much? Liquor _____ Beer _____ Wine _____
Do you currently smoke? Yes No If yes, how much? _____ How many years have you been smoking?_____
If you previously smoked, when did you quit? _____ How much? _____ How many years did you smoke?_____

### Medical History:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Bleeding Disorder | Yes | No | _____ | Stroke | Yes | No | _____ |
| High Blood Pressure | Yes | No | _____ | Seizure | Yes | No | _____ |
| High Cholesterol | Yes | No | _____ | Liver Disease | Yes | No | _____ |
| Valley Fever/TB | Yes | No | _____ | Kidney Disease | Yes | No | _____ |
| Asthma | Yes | No | _____ | Thyroid Disease | Yes | No | _____ |
| COPD/Emphysema | Yes | No | _____ | Intestinal Disease | Yes | No | _____ |
| Lung Disease | Yes | No | _____ | Alcohol/Drug Abuse | Yes | No | _____ |
| Diabetes | Yes | No | _____ | Cancer | Yes | No | _____ |
| Heart Disease/Murmur | Yes | No | _____ | | | | |
| Anesthesia Problems | Yes | No | _____ | | | | |

Other Major Medical Illness/Issues _____

_____

_____

### Surgical History (If yes, please provide type and approximate date):

| | | | | |
|---|---|---|---|---|
| Open Heart Surgery | Yes | No | _____ | Date _____ |
| Coronary Stent | Yes | No | _____ | Date _____ |
| Lung Surgery | Yes | No | _____ | Date _____ |
| Vein Ablation Surgery | Yes | No | _____ | Date _____ |
| Vascular Surgery | Yes | No | _____ | Date _____ |
| Cancer Surgery | Yes | No | _____ | Date _____ |
| Abdominal Surgery | Yes | No | _____ | Date _____ |
| Ortho/Joint Surgery | Yes | No | _____ | Date _____ |
| Other Surgery | Yes | No | _____ | Date _____ |

### Family History (If yes, please list whom):

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart Disease | Yes | No | _____ | Stroke/Seizure | Yes | No | _____ |
| High Blood Pressure | Yes | No | _____ | Bleeding Disorder | Yes | No | _____ |
| High Cholesterol | Yes | No | _____ | Kidney/Liver Disease | Yes | No | _____ |
| Aneurysm | Yes | No | _____ | Sudden Death | Yes | No | _____ |
| Lung Disease | Yes | No | _____ | Alcohol/Drug Abuse | Yes | No | _____ |
| Diabetes | Yes | No | _____ | Cancer | Yes | No | _____ |

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## Review of Systems

**Constitutional:**

| | | |
|---|---|---|
| Significant Weight Loss/Gain | Yes | No |
| Night Sweats or Chills | Yes | No |
| Fever | Yes | No |
| Exercise Intolerance | Yes | No |

**Eyes:**

| | | |
|---|---|---|
| Dry Eyes/Irritation | Yes | No |
| Visual changes | Yes | No |

**ENT:**

| | | |
|---|---|---|
| Difficulty Hearing | Yes | No |
| Nosebleeds | Yes | No |
| Sore Throat | Yes | No |
| Bleeding Gums | Yes | No |

**Cardiovascular:**

| | | |
|---|---|---|
| Chest Pain/Pressure | Yes | No |
| Chest Discomfort | Yes | No |
| Palpitations | Yes | No |

**Respiratory:**

| | | |
|---|---|---|
| Cough | Yes | No |
| Sputum Production | Yes | No |
| Wheezing | Yes | No |
| Shortness of Breath | Yes | No |
| Coughing up Blood | Yes | No |
| Sleep Apnea | Yes | No |

**Gastrointestinal:**

| | | |
|---|---|---|
| Poor appetite | Yes | No |
| Heartburn | Yes | No |
| Difficulty Swallowing | Yes | No |
| Abdominal Pain | Yes | No |
| Nausea | Yes | No |
| Vomiting | Yes | No |
| Vomiting Blood | Yes | No |
| Constipation | Yes | No |
| Diarrhea | Yes | No |
| Dark/Tarry Stools | Yes | No |
| Bloody Stools | Yes | No |

**Genitourinary:**

| | | |
|---|---|---|
| Incontinence | Yes | No |
| Frequent Urination | Yes | No |
| Blood in Urine | Yes | No |
| Foley Catheter Issues | Yes | No |

**Musculoskeletal:**

| | | |
|---|---|---|
| Muscle Aches | Yes | No |
| Muscle Weakness | Yes | No |
| Joint Pain | Yes | No |
| Back Pain | Yes | No |
| Lower Extremity Swelling | Yes | No |

**Neurologic:**

| | | |
|---|---|---|
| Loss of Consciousness | Yes | No |
| Fainting/Syncope | Yes | No |
| Weakness | Yes | No |
| Numbness | Yes | No |
| Seizures | Yes | No |
| Dizziness | Yes | No |
| Lightheadedness | Yes | No |
| Headaches/Migraines | Yes | No |
| Tremor | Yes | No |
| Balance/Gait Issues | Yes | No |

**Skin:**

| | | |
|---|---|---|
| Rash | Yes | No |
| Sores/Ulcers | Yes | No |

**Psychiatric:**

| | | |
|---|---|---|
| Depression | Yes | No |
| Anxiety | Yes | No |
| Sleep Disturbance | Yes | No |
| Alcohol Abuse | Yes | No |

**Hematologic:**

| | | |
|---|---|---|
| Easy Bruising | Yes | No |
| Excessive Bleeding | Yes | No |
| Swollen Glands | Yes | No |

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# Release of Information & Policies

Name (Last, First Middle) _____ DOB: _____

## Release of Information

### Release of Medical Information

I authorize Western Cardiothoracic Surgeons, to release and receive the medical records concern my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

### Release of Electronic Medical Information

I authorize Western Cardiothoracic Surgeons, to release and receive, through the CCHIT software that meets or exceeds the Federal standard for encrypted electronic medical records concerning my son/daughter/self to/from any pharmacy, physician, hospital, or agency involved in the care of the patient listed.

## Assignment of Medical Benefits

I request payment under the insurance policy of the card that was presented at the time of service be made directly to me or the provider listed on any claim for services furnished to me during the effective period of this authorization

I authorize Western Cardiothoracic Surgeons, to release to the Social Security Administration, its intermediaries or carriers any information required for this claim or any related Medicare claim. I authorize the release of any information necessary to determine these benefits payable for related services.

## Policies

### HIPAA Policy

I have either read or received the written copy of Western Cardiothoracic Surgeons' Health Information Portability and Accountability Act and understand that my health information will be protected by this act according to the written policy of Western Cardiothoracic Surgeons. If further information is needed, please request to speak with our HIPAA Privacy Officer at (480) 248-3000.

### Payment Policy

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa, and Mastercard. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

### Referral Policy

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature: _____ Date: _____

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# PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Name (Last, First Middle) _____ DOB: _____

By signing this form, I give permission to the person(s) listed below to receive limited information about my care. I understand my healthcare provider will use their professional judgement to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

| Date Permission Given | Name of Individual to Receive Info | Relation to Patient | Comments/Instructions: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## THE PHYSICIAN/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

- ☐ Leave message at home with my spouse. Name: _____ Relationship: _____
- ☐ Leave message on cell phone. Cell Phone Number: _____
- ☐ Leave message at work. Work Phone Number: _____
- ☐ Leave message on voicemail. Phone Number: _____
- ☐ Leave a detailed message on answering machine. Phone Number: _____

_____ _____
Signature of Patient or Legal Guardian  Date

_____ _____
Printed Name of Patient or Legal Guardian  Relation

## Your Health Information Rights:

*Copy of this Notice.* You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

*Inspect and Copy.* You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial.

If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our privacy officer at the practice's address set forth in this Notice. We may charge you a few for the cost of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice sites. If the information is stored off-site, we have up to 60 days to respond, but must inform you of this delay.

*Request Amendment.* You have the right to request that we amend your protected health information. You must make this request in writing to our privacy officer. The request must state the reason for the amendment.

We may deny your request if it is not in writing or does not state the reason for the amendment. We may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.

*Request Restrictions.* You have the right to request a restriction or limitation of how we use or disclose your protected health information for treatment, payment, or health care operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although we are not required to agree to your requested restriction, if we do agree, we will comply with your request unless the information is needed for emergency treatment. Please contact our privacy officer as set forth in this notice to request a restriction.

*Accounting of Disclosures.* You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operation; to you; incident to a use or disclosure set forth in this notice; to person involved in your care; pursuant to your written authorization; for notification purposes; for national security or intelligence purposes; to correctional institutions or law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information.

Your first request for a list of disclosures within a 12-month period will be free. If your request an additional list within 12 months of the first request, we may charge you a fee for the costs providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

*Request Confidential Communications.* You have the right to request how we communicate with you to preserve your privacy. We may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our privacy officer. The request must specify how or where we are to contact you. We will accommodate all reasonable requests.

*File a Complaint.* You have the right to file a complaint with our privacy officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our administrator must be in writing. We will not retaliate against you for filing a complaint.

## For More Information:

If you have questions or would like additional information, you may contact our privacy officer at (480) 248-3000.

Western Cardiothoracic Surgeons
1830 S. Alma School Rd, Suite 108
Mesa, AZ 85210

Effective Date: December 8, 2009

# NOTICE OF PRIVACY PRACTICES


**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. We will post any revision notice in a prominent location in our office and, upon request, will provide you with a copy of the revised notice.

## Uses and Disclosure of Your Protected Health Information:

*Treatment.* We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. We may also disclose your protected health information to other health care providers who may be treating you or involved in your health care. For example – we may disclose your protected health information to your primary care physician.

*Payment.* We may use and disclose your protected health information to obtain payment for health care services we provide you or determine whether we may obtain payment for services we recommend for you. We may also disclose your protected health information to another health care provider, health care clearinghouse, or health plan for their payment activities. For example – we may include with a bill to a third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

*Health Care Operations.* We may use and disclose your protected health information to support our business activities. For example – we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may disclose your protected health information to another care provider, health care clearinghouse, health plan, or "organized health care arrangement" we participate in, for certain health care operations. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g. billing services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

*Appointment Reminders and Treatment Alternative.* We may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment, or to tell you about or to recommend possible alternative treatments or other health-related benefits or service that may be of interest to you.

*Persons Involved in Your Care.* We may use and disclose to a family member, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless your object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgement.

*Notification.* We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or person responsible for your care, of your location, general condition, or death.

*Disaster Relief.* We may use and disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

*Research.* We may use and disclose your protected health information for research projects – e.g., for a project studying the effectiveness of a treatment. Generally, such research projects must have been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

*As Required by Law.* We may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.

*Public Health.* We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury, or disability. If directed by the public health authority, we may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.

*Abuse or Neglect.* We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If we believe you are a victim of abuse, neglect, or domestic violence, we also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.

*Communicable Diseases.* If authorized by law, we may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

*Legal Proceedings.* We may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request, or other lawful process.

*Law Enforcement.* If certain legal requirements are met, we may disclose your protected health information to a law official for law enforcement purposes, including legal processes; identification and location of suspects, fugitives, material witnesses, or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.

*Coroners, Funeral Directors, and Organ Donation.* We may disclose your personal health information to a coroner or medical examiner for the identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties or in reasonable anticipation of death. Finally, we my use or disclose your protected health information for facilitating organ, eye, or tissue donation and transplantation.

*To Avert a Serious Threat to Public Health or Safety.* Consistent with applicable laws, if we believe using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public, we may use and disclose your protected health information. We may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.

*Military Activity and National Security.* When appropriate conditions apply, we may use or disclose your protected health information: (1) for activities deemed necessary by appropriate military command authorities; (2) for determining your eligibility for benefits by the Department of Veterans Affairs; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

*Workers' Compensation.* We may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

*Department of Health and Human Services.* As required by law, we may disclose your protected health information to the Department of Health and Human Service to determine our compliance with applicable laws.

*Written Authorization.* Except as stated in this notice, we will not use or disclose your protected health information without your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have used or disclosed your information in reliance on the authorization.

*Food and Drug Administration.* We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, tracked products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.

*Inmates.* We may use and disclose your protected health information if you are an inmate of a correctional facility, and we created or received your protected health information in the course of providing your care.